Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be reimbursement for dates of service 7-27-01 and 7-28-01.
   b. The request was received on 5-2-02.

II. EXHIBITS

1. Requestor, Exhibit I:
   a. TWCC 60 and Letter Requesting Dispute Resolution
   b. UB-92s
   c. EOBs/TWCC 62 forms
   d. Medical Records
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:
   a. Response to Request for Dispute Resolution
   b. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome

3. No carrier sign sheet was noted in the dispute packet. The carrier's three (3) day response is reflected in Exhibit II of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Letter dated 7-15-02:
   "Our facility performed outpatient/ambulatory surgery for the above-mentioned patient on 07/27/01….On 9/19/01, we received a reimbursement of $3761.70 for a $22,481.36 claim….We do not deem this reimbursement as fair and reasonable….There is no set fee guideline for Outpatient/Ambulatory services; therefore it appears that processing this claim at a per diem rate/plus the cost of implants is not adequate."

2. Respondent: Letter dated 6-28-02:
"In this case, the insurance carrier and / or its board representative did not receive the additional documentation from the Commission. The requestor did not send the additional documentation to the Commission and / or the Commission did not forward a copy of the additional documentation to the insurance carrier."

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only dates of service eligible for review are 7-27-01 and 7-28-01.

2. The carrier denied the billed services as reflected on the EOB as, "M – NO MAR, REDUCED TO FAIR AND REASONABLE; 0 – DENIAL AFTER RECONSIDERATION".

3. The Requestor billed the Respondent $22,481.36

5. 4. The Respondent paid $3,761.70

6. 5. The Requestor is seeking (according to the Table of Disputed Services) additional reimbursement in the amount of $15,707.08.

6. The services provided by the Requestor include such items as anesthesia and lab services, pharmaceutical products, medical and surgical supplies, sterile supplies and EKG.

V. RATIONALE

Medical Review Division's rationale:

The medical documentation indicates the services were performed at an outpatient/ambulatory surgical center. Pursuant to Rule 133.307 (g) (3) (D), the requestor must provide "…documentation that discusses, demonstrates and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement …".

The carrier, according to their denial on the EOB, asserts that they have paid a fair and reasonable reimbursement, but has not submitted a methodology to support its reimbursement Per Rule 133.304 (i), "When the insurance carrier pays a health care provider for treatment(s) and/or service(s) for which the Commission has not established a maximum allowable reimbursement, the insurance carrier shall:

1. develop and consistently apply a methodology to determine fair and reasonable reimbursement amounts to ensure that similar procedures provided in similar circumstances receive similar reimbursement;

2. explain and document the method it used to calculate the rate of pay, and apply this method consistently;

3. reference its method in the claim file; and

4. explain and document in the claim file any deviation for an individual medical bill from its usual method in determining the rate of reimbursement."

The response from the carrier shall include, per Rule 133.307 (j) (1) (F), ".... if the dispute involves health care for which the Commission has not established a maximum allowable reimbursement, documentation that discusses, demonstrates, and justifies that the amount the respondent paid is a fair and reasonable rate of reimbursement in accordance with Texas Labor Code 413.011 and §133.1 and 134.1 of this title;".

Due to the fact that there is no current fee guideline for ASCs, the Medical Review Division has to determine, based on the parties' submission of information, who has provided the more persuasive evidence. The Respondent has failed to supply a methodology to support their denial. However, as the requestor, the health care provider has the burden to provide documentation that "…discusses, demonstrates, and justifies that the payment being sought is fair and reasonable rate of reimbursement…." pursuant to TWCC Rule 133.307 (g) (3) (D). The requestor has submitted medical records associated with the claimant's procedure and stay, however, no documentation was noted that discusses, demonstrates, and justifies that the billed amount represents a fair and reasonable charge.

The requestor has failed to support their position that the amount billed is fair and reasonable.

No additional reimbursement is recommended.

REFERENCES: The Texas Workers' Compensation Act & Rules: Sec 413.011 (d); Rule 133.304 (i); Rule 133.307 (g) (3) (D), and (j) (1) (F).

The above Findings and Decision are hereby issued this 20th day of February 2003.

Lesa Lenart
Medical Dispute Resolution Officer
Medical Review Division

LL/ll